

KENTUCKY PATIENT ACCESS AND CARE SYSTEM (KenPAC) PRIMARY CARE CASE MANAGEMENT AGREEMENT

CONTRACT TO PROVIDE PRIMARY CARE CASE MANAGEMENT BETWEEN THE COMMONWEALTH OF KENTUCKY DEPARTMENT FOR MEDICAID SERVICES AND

Provider Name (Please print legibly or type)

Kentucky Medicaid ID Number

NPI (National Provider Identifier) Number

Provider Tax Identification Number

This agreement is entered into between the commissioner of the Department for Medicaid Services, hereinafter referred to as DMS, and the above named Kentucky Medicaid provider, hereinafter referred to as a Primary Care Case Manager (PCCM) or Primary Care Provider (PCP) or the practice whose address and phone number is:

(Address) _____

(City) _____ (State) _____ (Zip Code) _____

(Phone) _____

Purpose

The purpose of this agreement is to obtain primary care case management services for beneficiaries participating in the Kentucky Patient Access and Care System (KenPAC). The goal of KenPAC as a primary care case management system of Medicaid is to increase access to primary and preventive care services, thereby enhancing the health status of enrollees and reducing future health care expenditures. This agreement is made pursuant to Title XIX of the Social Security Act and amendments thereto and Title 907, chapter 1, Section 320, of the Kentucky Administrative Regulations.

This contract supersedes all previous KenPAC primary care case management contracts and amendments thereto.

A PCCM or PCP may be individual physicians, Advanced Registered Nurse Practitioners (ARNP), group practices, Federally Qualified Health Care Centers (FQHC), rural Health Clinics (RHC) or Primary Care Centers/Clinics.

The agreement outlines the responsibilities of the PCCM/PCP and DMS. Services to be provided by the PCCM/PCP shall be consistent with the licensure and certification of the PCCM/PCP and will cover only those services deemed payable under the Kentucky State Plan.

Term: This contract shall become effective upon signature of both parties and shall remain in effect until otherwise amended or terminated pursuant to the terms of this agreement. Renegotiations will not be addressed.

Responsibilities of the PCCM/PCP

A. Establish a KenPAC quota up to a maximum of 1500 per full-time (40 hrs/wk) PCCM/PCP (a group practice with three full-time PCCM/PCP's may have a quota of 4500). This maximum limit may be waived upon request from the PCCM/PCP and at the discretion of DMS.

B. Provide reasonable and adequate hours of operation, including 24 hours a day, 7 days a week enrollee access to medical consultation, referral approval and treatment for emergency medical conditions. This 24/7 access may be direct or by telephone.

C. Provide primary care case management to each assigned KenPAC enrollee in accordance with the provisions of this agreement. He or she shall determine the necessity for and authorize when appropriate, non-emergency care covered under the KenPAC program.

D. Provide PCCM/PCP management services for the following: physician specialty services, prior authorization of prescription medications, hospital inpatient and outpatient services, ambulatory surgical center services, EPSDT services, home health services, primary care center services and rural health clinic services, advanced registered nurse practitioner specialty services, durable medical equipment and medical supplies, laboratory services, radiological services, pharmacy services as prescribed by the PCCM/PCP, physical therapy services, occupational therapy services, and speech therapy services. (**Note:** Abortion is a service.)

E. Assist the KenPAC enrollee in obtaining and educate the KenPAC enrollee on the following direct access services: emergency services, mental health services, ophthalmological services, optometry or eyeglass services, maternity care services, podiatry services, general medical transportation services, emergency or non-emergency ambulance services, EPSDT services, services provided by the Kentucky Early Intervention Services Program, services provided by an audiologist or hearing aid dealer, hearing aid services, family planning services, services provided through the Medicaid preventive service program, chiropractic services, newborn care services, services provided by a specialized children's service clinic, services provided by a Health Access Nurturing Development Service (HANDS) provider, and school-based services.

F. Coordinate care in such a manner that all available program options are utilized as they relate to any special health care needs of the enrollee, i.e., Women Infants and Children (WIC) program, Local Health Departments, Commission for Children with Special Health Care Needs.

G. Make arrangements with sufficient numbers of physicians and/or other practitioners to ensure services under the agreement can be furnished to KenPAC enrollees promptly and without compromising quality of care.

H. Make referrals for specialty services, as determined by medical necessity, to participating Medicaid providers. (If a specialist, to whom the PCCM/PCP has made a referral, determines the enrollee needs to see another specialist, the specialist needs to get a referral from the PCCM/PCP. The PCCM/PCP is responsible for explaining this process to both the Specialist and the enrollee.)

Note: A PCCM/PCP may otherwise perform or make referrals for abortions when the pregnancy is the result of rape or incest or when the female recipient suffers from a physical disorder, injury, or illness, including a life endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the recipient in danger of death unless an abortion is performed.

I. When an enrollee is assigned to the practice and the enrollee is already being treated by a specialist from a previous referral, allow the specialty services to continue through referral until the enrollee can be scheduled for an appointment to determine medical needs.

J. Provide the KenPAC enrollee a referral for a second opinion when surgery or other extensive services or procedures are recommended. The KenPAC provider shall render treatment personally or through referral after receipt of the second opinion.

K. Assure DMS that the KenPAC enrollee will receive the required amount, scope, and duration of medical care necessary for the successful treatment of the enrollee's health condition.

L. Promote and provide EPSDT services for all enrollees age 20 and under and provide additional benefits which are covered for EPSDT eligibles or provide a written referral to an appropriate specialist if not performed by the practice.

M. Provide the PCCM/PCP referral number for enrollees requiring emergency associated inpatient or outpatient post-stabilization treatment.

N. Support the current benefit plan as outlined above in item D at no additional cost to the recipient, i.e., may not charge for providing prior authorization of prescriptions.

O. Not charge KenPAC enrollees for missed appointments or for advice.

P. Not balance bill KenPAC enrollees but accept the Medicaid payment as payment in full. If a KenPAC enrollee has third party liability coverage the PCCM/PCP must bill the insurance carrier before billing Medicaid. If the third party payment is less than the Medicaid rate for the service provided then Medicaid will pay the difference. Otherwise, the third party payment will cover the service as payment in full.

Q. Create and maintain a patient medical record for each KenPAC enrollee assigned to the practice that contains, at a minimum, the Medicaid/KenPAC identification number, name, age, gender, address, documentation of services provided, where provided and by whom, medical diagnosis, treatment, therapy, and medications prescribed and or administered. Also, the provider will document all authorizations for covered services provided by the other providers. Additionally, all medical records must comply with federal requirements for utilization control.

R. Retain financial records, supporting documents, statistical records, and all other records pertinent to an award for a period of five years from the date of submission of the final expenditure report or, for awards that are renewed quarterly or annually, from the date of the submission of the quarterly or annual financial report. The only exceptions are the following: if any litigation, claim, financial management review, or audit is started before the expiration of the five-year period, the records shall be retained until all litigation, claims, or audit findings involving the records have been

resolved and final action taken; records for real property and equipment acquired with federal funds shall be retained for five years after final disposition; when records are transferred to or maintained by the HHS awarding agency, the five-year retention requirement is not applicable to the recipient; or, indirect cost rate proposals, cost allocation plans, etc., as specified in 45 CFR 74.53(g).

S. Transfer an enrollee's medical record, upon written request from the enrollee, to the receiving PCCM/PCP when the enrollee has changed his/her primary care provider.

T. Allow unrestricted access to the practice's medical and financial records at any time deemed necessary by the federal and/or state government in order to assure quality, appropriateness, or timeliness of services and reasonableness of cost.

U. Review member utilization reports provided by the Medicaid program and advise the Medicaid program of any errors, omissions, or discrepancies of which the provider may be aware.

V. Make required coverage arrangements when in absence from the practice. The back-up provider must be notified by the PCCM/PCP of the absence as well as the PCCM/PCP's answering service.

W. Complete KenPAC surveys as required by DMS.

X. Respond to random requests from DMS for verification that specific services paid were actually authorized by the PCCM/PCP.

Y. Give DMS and enrollees assigned to the practice a minimum of 30 days' notice prior to the closing of the practice or termination of KenPAC participation so DMS may notify KenPAC enrollees to select a new primary care provider. Failure to notify DMS and an enrollee or a practice closing shall have a bearing upon whether the PCCM/PCP may participate in the KenPAC program at a future date.

Responsibilities of DMS

A. Determine eligibility requirements for Medicaid KenPAC recipients and indicate eligibility on the Kentucky Medicaid Identification Card issued to enrollees.

B. Assign KenPAC enrollees to a PCCM/PCP, as requested by the recipient, up to the allowable maximum of 1500 per full-time PCCM/PCP. This maximum limit may be waived upon request from the PCCM/PCP and at the discretion of DMS.

C. Geographically limit a KenPAC enrollee to the selection of a PCCM/PCP that practices within the enrollee's Medical Service area. Only under limited circumstances may an enrollee select medical service area and then only with DMS approval.

D. At the time of initial enrollment, provide each potential enrollee with information that enables the potential enrollee to make an informed decision about the selection of a PCCM/PCP. Information to be provided shall include but not be limited to:

1. Basic features of the PCCM/PCP form of managed care
2. Populations excluded from mandatory KenPAC enrollment
3. PCCM/PCP responsibilities for coordination of enrollee care
4. A summary of information specific to each PCCM/PCP operating in the enrollee's medical service area, which shall include, but not be limited to, benefits covered; cost sharing, if any; identification of the medical service area; names, locations, telephone numbers and non-English languages spoken by current PCCP/PCP in the medical service area; and, identification of PCCM/PCP's that are not currently taking new patients
5. Benefits available under the State plan but are not covered under the contract, including how and where to obtain those benefits, if there is any cost sharing, and how transportation is provided
6. Procedures for obtaining benefits: If any significant change should occur in this information the state shall notify

enrollees of the change 30 days prior to the effective date of the change.

E. After learning of a PCCM/PCP closure or termination from the KenPAC program, make a good faith effort to notify enrollees within 15 days.

F. Provide the PCCM/PCP with a list of enrollees each month. (Some slight variance may occur from month to month.)

G. Pay each PCCM/PCP a monthly case management fee of four dollars (\$4.00) for each KenPAC enrollee assigned to his or her practice. This shall be done in aggregate for the month the fees are incurred according to the appropriate DMS billing cycles. DMS will also provide reimbursement for medical services performed in accordance with the fee for service or cost-based payment specified by regulation for such services.

H. Process grievances and state fair hearing requests in a timely manner.

I. Conduct reviews of a KenPAC provider's compliance with the requirements of this agreement and to assure the provision of quality care.

General Provisions

Enrollment: Enrollment in the Kentucky Patient Access and Care System (KenPAC) is mandatory for the eligible population, except as excluded by federal and state regulations. Enrollment, disenrollment and re-enrollment for the mandatory non-SSI population will be accomplished through the efforts of the Cabinet for Families and Children, the Department for Community Based Services (DCBS). Enrollment, disenrollment, and re-enrollment for the mandatory SSI population will be accomplished through the efforts of DMS.

The PCCM/PCP shall not discriminate on the basis of health status, need for health care services, race, color, or national origin, no will the PCCM/PCP use any policy or procedure that has the effect of such discrimination.

The PCCM/PCP, in a group practice setting, shall choose whether to have enrollees assigned to the group or to the individual physicians practicing with the group.

Each enrollee shall be assigned to a PCCM/PCP of their choice upon initial enrollment. A default enrollment process will be placed in operation for enrollees who fail to select a PCCM/PCP. This default process shall be based upon historical usage or an equitable distribution among eligible providers within the enrollee's county of residence.

Disenrollment: The PCCM/PCP may request the disenrollment of a KenPAC enrollee from the practice only for the following reasons: an inability to adequately meet the medical needs of the enrollee, incompatibility in the provider/patient relationship, health-related uncooperative behavior disrupts or interferes with the PCCM/PCP's ability to furnish services to the enrollee or other patients of the practice, or, for a reason that DMS has determined, it would be in the best interest of the enrollee to select a new PCCM/PCP.

By signing this agreement, the PCCM/PCP assures DMS the practice will not disenroll an enrollee for any reason other than just specified.

The PCCM/PCP may not request the disenrollment of a KenPAC enrollee from the practice due to a change in the enrollee's health status, utilization of medical services, diminished mental capacity, or uncooperative behavior that results from the special health care needs of the enrollee.

The PCCM/PCP must submit a disenrollment request in writing to DMS 30 days prior to the effective date of the disenrollment. The PCCM/PCP must also notify the KenPAC enrollee of the disenrollment in writing 30 days prior to the disenrollment, explaining the reason for the request. During the 30-day period prior to disenrollment, the PCCM/PCP must continue to provide care to the enrollee.

An enrollee may request disenrollment from a PCCM/PCP's practice any time with cause. Cause reasons shall be: the provider is not qualified to treat the enrollee's health care needs; the enrollee was denied access to a needed medical service; the enrollee received poor quality of care; the provider does not offer a

service because of moral or religious objections; or, the enrollee was homeless or a migrant worker at the time of enrollment and was enrolled with his or her practice by default.

An enrollee may request disenrollment from a PCCM/PCP's practice without cause within ninety (90) days of the enrollee's enrollment or the date DMS notified the member of initial enrollment, at least once every twelve (12) months after initial enrollment, upon recertification if a temporary loss of Medicaid eligibility for six (6) months or less has caused the member to miss an annual disenrollment opportunity, if DMS imposes a sanction on the PCCM/PCP, or if the enrollee and KenPAC provider are no longer located within the same medical service area.

When DMS receives a request from an enrollee to change a KenPAC provider for cause reasons, DMS will act upon that request so it can be effective by the first of the second month following the month the request was made. If DMS does not act upon the request in a timely manner, the request shall be considered approved.

An enrollee's oral request to disenroll from a PCCM/PCP's practice shall be followed up in writing.

Re-enrollment: For re-enrollment purposes, the PCCM/PCP may not discriminate based on the recipient's health status or need for health care services.

Lock-In Program: If through utilization review, it is determined that an enrollee is over-utilizing or abusing Medicaid benefits the enrollee can be disenrolled from the KenPAC program and placed in the Medicaid Lock-In program.

Enrollee's Rights and Protections

A PCCM/PCP must comply with any applicable federal and state laws that pertain to an enrollee's rights and ensure that staff and affiliated providers take such rights into account when furnishing services. The PCCM/PCP must also comply with applicable laws such as title VI of the Civil Rights Act of 1964; title IX of the Education Amendments of 1972 (regarding education programs and activities); the Age Discrimination Act of 1975; the Rehabilitation Act of 1973; and the Americans with Disabilities Act.

The PCCM/PCP shall also comply with federal or state laws concerning an enrollee's right to privacy and confidentiality.

The PCCM/PCP shall treat each KenPAC enrollee assigned to the practice with dignity and with due consideration of his or her privacy. The PCCM/PCP shall also respect the KenPAC enrollee's rights to receive information on available treatment options and alternatives, to participate in decisions regarding his or her health care, including the right to refuse treatment, to be free from any form of restraint or seclusion used as a means of coercion, discipline, convenience, or retaliation, and to receive a copy of his or her medical records and to request they be amended as specified in 45 CFR part 164. The PCCM/PCP also agrees that when a KenPAC enrollee exercises these rights, the practice will not allow such action to adversely affect the way the enrollee is treated.

Enrollees shall also have the right to choose their own PCCM/PCP in respect to the limits of the kenPAC program.

Enrollees shall have the right to appeal any denial relating to either eligibility or covered service authorizations. They may also ask the PCCM/PCP or DMS whether a service is covered before receiving it.

Admitting Privileges

The PCCM/PCP must have full admitting privileges or have an established protocol with a physician who has admitting privileges at one or more hospitals operating in the area of the practice. Any changes in admitting privileges must be immediately reported to DMS.

Emergency Services

Emergency services do not require prior authorization from the PCCM/PCP for payment of services. Emergency services may be performed regardless of location or provider.

Written Materials and Oral Interpretation Services

The PCCM/PCP shall make any written information regarding the practice in easily understood language and format as well as in the prevalent non-English languages spoken in the practice's service area.

The PCCM/PCP shall also provide oral interpretation services available free of charge to each KenPAC potential enrollee and enrollee regardless of language.

The PCCM/PCP shall also provide written information in alternative formats that takes into consideration the special needs of those KenPAC enrollees who are communicationally impaired.

The PCCM/PCP shall notify his or her KenPAC enrollees that such language services are available and how to access those services.

DMS will do likewise in regard to any information it is responsible for providing to the KenPAC enrollee.

Marketing

The PCCM/PCP agrees not to distribute any marketing material for the purpose of enrollee enrollment without first obtaining approval from DMS.

The PCCM/PCP must assure DMS that the material is accurate and that it does not mislead, confuse or defraud enrollees or the state, nor does it seek to influence an enrollee in conjunction with the sale or offering of any private insurance.

The material provided by the PCCM/PCP may not contain any assertion or statement that the recipient must enroll with the provider in order to obtain Medicaid benefits. The material distributed by the PCCM/PCP shall not include any assertion or statement that the practice is endorsed by the Center for Medicare and Medicaid Services or the Department for Medicaid Services.

Once the PCCM/PCP obtains approval from DMS, he or she must distribute the material to his or her entire service area.

Prohibitions

A PCCM/PCP may not knowingly have a relationship with an individual, or affiliate thereof, who is dis-barred, suspended or otherwise excluded from participating in procurement activities under the Federal Acquisition Regulation or from participating in non-procurement activities under regulations issued under Executive Order No. 12549 or under guidelines implementing said Order. (*"Relations is described as a director, officer, or partner of the PCCM/PCP; a person with beneficial ownership of 5% or more of the PCCM/PCP's equity; a person with an employment, consulting, or other arrangement with the PCCM/PCP's obligations under its contract with DMS"*)

Federal Financial Payments (FFP) shall not be available for providers, who are excluded from Medicare, Medicaid, or S-Chip, except in emergency situations.

Sanctions and Termination of Agreement

If it is found the PCCM/PCP has been non-compliant with the terms and conditions of this agreement, DMS will give the PCCM/PCP six (6) weeks to develop a corrective action plan. If, after six (6) weeks, the provider has not submitted a satisfactory corrective action plan then DMS may terminate the PCCM/PCP's participation from the KenPAC program and notify recipients of the termination, giving them the right to select another PCCM/PCP.

The KenPAC PCCM/PCP shall receive written notification of the intent to terminate his or her standing in the KenPAC program along with the

reasons for the proposed termination. Upon notice of the intended termination the PCCM/PCP may request a pre-termination hearing that shall be conducted in accordance with the provisions of 907 KAR 1:671. The PCCM/PCP shall receive written notice regarding the outcome of the pre-termination hearing. If the hearing officer affirms the agency's decision to terminate the PCC/PCP's participation in the KenPAC program, KenPAC recipients shall be notified in writing of their right to select another PCCM/PCP.

Either party may cancel this agreement at any time without cause upon giving the other party written notice 30 days in advance of the effective date of the cancellation.

Upon termination of this agreement the PCCM/PCP shall supply all necessary information for reimbursement of outstanding Medicaid claims.

Recoupment of Management Fee

DMS may recoup case management fees/payments when DMS has determined through reliable evidence that an overpayment has occurred. The amount to be recouped shall be equal to the amount of the overpayment.

Recoupment shall take place either through withholding future management fees or by way of direct billing to the PCCM/PCP.

A recoupment action shall remain in effect until the overpayment is recovered, DMS enters into an agreement with the PCCM/PCP for recovery of the overpayment, DMS determines an overpayment does not exist, or until DMS is notified by the Center for Medicare and Medicaid Services (CMS) that the recoupment action is not pursuant to federal regulations.

Grievances

A grievance procedure will be established by DMS in order to resolve concerns of enrollees or providers relative to services received or provided.

Assignment

This agreement, including the rights, benefits, patient quota or duties hereunder shall not be assigned in whole or in part either directly or indirectly by either party. This clause shall not be construed to forbid the PCCM/PCP from arranging coverage for the PCCM/PCP's vacation or other off duty hours. The PCCM/PCP shall not subcontract any part of this agreement.

Confidentiality

The PCCM shall comply with any and all applicable federal and state laws and regulations regarding safeguarding the health information of a KenPAC enrollee.

Legal Compliance

This contract must comply with all federal and state laws and regulations, including, but not limited to, title VI of the Civil Rights Act of 1964, title IX of the Education Amendments of 1972 (regarding education programs and activities), the Age Discrimination Act of 1975, the Rehabilitation Act of 1973, the Americans with Disabilities Act, the Byrd Anti-Lobbying Amendment and Equal Employment Opportunity Mandates. Additionally, no agreement will be made to parties listed on the General Services Administration's List of Parties Excluded from Federal Procurement or Non-Procurement Programs.

The PCCM/PCP agrees that federal funds have not and shall not be utilized for lobbying purposes.

IN WITNESS WHEREOF, the parties hereto have caused this instrument to be executed by their duly authorized official or officers.

Signature of PCCM/PCP

Date of Signature

Conflict of Interest

Officials and representatives of DMS and its contractors may not and shall not have any interest in the enrollment of Medicaid beneficiaries into the Kentucky Patient Access and Care System (KenPAC). PCCM/PCP's shall report to DMS any such potential conflicts of interest.

Appeals

907 KAR 1:671 shall govern appeals made by the PCCM while 907 KAR 1:563 shall govern appeals made by the enrollee regarding any adverse action taken by an employee of DMS acting under the auspices of this agreement.

Modifications

This agreement shall be modified only by the written consent of the parties hereto. This agreement may be superseded or amended by changes in federal or state laws, regulations, or interpretations of the same by DMS.

Attachments

The following must be completed and/or signed to indicate the enrolling PCCM/PCP understands the terms and conditions that regulate the KenPAC program:

- Attachment A - Provider Enrollment Information
- Attachment B - Definitions.

Signature of KenPAC Representative

Date of Signature

Please return form to:
Kentucky Medicaid
P.O. Box 2110
Frankfort, KY 40602-2110

Provider Enrollment Information

The provider must complete this section if the agreement is to be valid. Information contained on this form **MUST** be accurate and correct. If any change occurs altering this information the provider is obligated to report the change within 30 days after the change occurs.

The following information may be made available to KenPAC enrollees to assist with the selection of a Primary Care Case Manager/Primary Care Provider. Please provide the information exactly as you wish it to appear on the provider roster given to the KenPAC enrollee.

SECTION A: Enrollment Conditions			
1. Indicate the number of KenPAC enrollees you will accept in your practice (maximum of 1500 per full-time PCCM/PCP - 40 hours a week) _____			
SECTION B: Practice Identification			
1. Indicate the specialty of your practice. <input type="checkbox"/> Family Practitioner <input type="checkbox"/> General Practitioner <input type="checkbox"/> Internist <input type="checkbox"/> Pediatrician	<input type="checkbox"/> Advanced Registered Nurse Practitioner <input type="checkbox"/> Family Practice <input type="checkbox"/> OB/GYN <input type="checkbox"/> Primary Care Center <input type="checkbox"/> Rural Health Clinic		
2. Indicate whether you are an individual practice or a group Practice. <input type="checkbox"/> Individual <input type="checkbox"/> Group			
3. If an individual practice, please indicate the following: _____ Degree _____ _____, _____ Kentucky Medicaid Number _____ NPI (National Provider Identifier) Number _____			
4. If you indicated you are a group practice, please choose whether to have KenPAC enrollees assigned to the group or to individual PCCM/PCP's. <input type="checkbox"/> Group <input type="checkbox"/> Individual			
5. If you are a group practice, please indicate each individual PCCM/PCP that will be practicing with the group. Attach additional pages if necessary.			
Name	Degree	KY Medicaid Number	NPI (National Provider Identifier) Number

SECTION C: Admitting Privileges		
Please indicate the hospital(s) with which you or your sponsoring physician has admitting privileges.		
Name	Location	
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	
SECTION D: Primary and Secondary Languages Spoken in Practice		
Indicate "P" for Primary Language and "S" for Secondary Language(s)		
<input type="checkbox"/> English _____ <input type="checkbox"/> Bosnian _____ <input type="checkbox"/> Spanish _____ <input type="checkbox"/> German _____	<input type="checkbox"/> Russian _____ <input type="checkbox"/> Vietnamese _____ <input type="checkbox"/> French _____ <input type="checkbox"/> Other _____	
SECTION E: Back-up/Covering Providers		
Please indicate the providers who will be back-up or provide coverage in your absence. When possible, the provider should be a participating Medicaid Provider.		
Name	Address	Telephone Number
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	
	Address:	
	City/State/Zip	

	Address:		
	City/State/Zip		
	Address:		
	City/State/Zip		
	Address:		
	City/State/Zip		
SECTION F: Practice Site Locations			
Indicate the office sites at which you practice, if practicing at more than one site.			
Site 1	Name		
	Address		
	City/State/Zip		
	Days/Hours	Telephone	
	Medicaid Number	KenPAC Site Number	
	Quota (for this site only):	Age Range (for this site only):	
Site 2	Name		
	Address		
	City/State/Zip		
	Days/Hours	Telephone	
	Medicaid Number	KenPAC Site Number	
	Quota (for this site only):	Age Range (for this site only):	
Site 3	Name		
	Address		
	City/State/Zip		
	Days/Hours	Telephone	
	Medicaid Number	KenPAC Site Number	
	Quota (for this site only):	Age Range (for this site only):	
Site 4	Name		
	Address		
	City/State/Zip		
	Days/Hours	Telephone	
	Medicaid Number	KenPAC Site Number	
	Quota (for this site only):	Age Range (for this site only):	

SECTION G: Enrollee Access Telephone Number (One telephone number only)

My 24 hour, 7 day per week, access number is _____

I understand this number shall be printed on the Medicaid Identification Card of the KenPAC enrollees assigned to the practice.

As an authorized representative of the practice, I affirm that the information provided on this form is true to the best of my knowledge. I acknowledge that if I have knowingly provided information that is of a false nature, that the practice shall forfeit its participation in the KenPAC program and be subject to any or all appropriate fines and sanctions.

Authorized Signature

Title

_____, _____
Date

DEFINITIONS RELATED TO THE KenPAC PROVIDER AGREEMENT

Action: action taken in regard to the enrollee's Medicaid status or service authorization by either the PCCM/PCP or DMS that is of an adverse nature

Advanced Registered Nurse Practitioner: Shall refer to the definition provided in accordance with KRS 314.011(7)

Cold Call Marketing: Any unsolicited personal contact by the PCCM/PCP with a potential enrollee for the purpose of marketing

DMS: Kentucky Department for Medicaid Services

Disenrollment: The termination of a recipient and PCP relationship

Emergency Medical Condition: A medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual, or with respect to a pregnant woman, the health of the woman and her unborn child, in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part

Enrollee: A Medicaid eligible recipient who has been enrolled in the KenPAC program

EPSDT: The early and periodic screening, diagnosis and treatment services provided to Medicaid eligible children under Title XIX of the Social Security Act, 42 USC 1396, and ET. Seq.

Grievance: Dissatisfaction expressed verbally or in writing by an enrollee or PCCM/PCP relative to services received or provided

Marketing: Any communication from a PCCM/PCP to a Medicaid enrollee who is not enrolled with the practice that can reasonably be interpreted as intended to influence the enrollee to enroll in the practice or to not enroll with or disenroll from another PCCM/PCP

Marketing Material: Material produced in any medium by or on behalf of a PCCM/PCP that can reasonably be interpreted to market to potential employees

Medical Service Area: Contains the county of residence/practice along with bordering counties

Medically Necessary or Medical Necessity: A covered benefit is determined to be needed in accordance with 907 KAR 3:130

PCCM/PCP: Primary Care Case Manager/Primary Care Provider

Primary Care Center: A health facility operating in accordance with 907 KAR 1:054

Potential Enrollee: Medicaid recipient who is subject to mandatory enrollment in the KenPAC program but has not selected a PCCM/PCP

Rural Health Clinic: A facility operating in accordance with 907 KAR 1:082

Specialist: A physician whose practice is limited to a particular branch of medicine or surgery, including one whom, by virtue of advanced training, is certified by a specialty board as qualified to so limit their practice

Practice: Business entity either composed of an individual physician providing medical care or a group of physicians providing medical care.

I have read and understand the above terms as they relate to the KenPAC Provider Agreement.

Signature of PCCM/PCP

Date

Please return form to: Kentucky Medicaid, P.O. Box 2110, Frankfort, KY 40602-2110